No. 02-5664 (4)

DEC 17 2002

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In The
Supreme Court of the United States

CHARLES THOMAS SELL, D.D.S.,

Petitioner,

v.

THE UNITED STATES OF AMERICA,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

JOINT APPENDIX
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May 16, 1997	Complaint Against Charles Thomas Sell, D.D.S. Signed, Cause No. 97CR290.
May 16, 1997	Charles Thomas Sell, D.D.S. Arrested and Detained.
May 20, 1997	Motion for Psychiatric Examination of Charles Thomas Sell, D.D.S. Filed by USA.
May 20, 1997	Motion for Psychiatric Examination of Charles Thomas Sell, D.D.S. Granted.
July 2, 1997	Report of Psychiatric Evaluation of Charles Thomas Sell, D.D.S. Filed.
July 15, 1997	Preliminary Examination and Detention Hearing Held; Testimony Presented; Charles Thomas Sell, D.D.S. Found Competent to Stand Trial.
July 30, 1997	Five Count Indictment of Charles Thomas Sell, D.D.S. Filed by USA, Cause No. 97CR290.
August 27, 1997	Conditions of Release of Charles Thomas Sell, D.D.S. Ordered; Bond Posted by Charles Thomas Sell.
November 6, 1997	Sixty-Three Count Superseding Indictment of Charles Thomas Sell, D.D.S. Filed by USA, Cause No. 97CR290.
January 22, 1998	Petition for Action on Conditions of Pretrial Release Filed by USA.

January 23, 1998	Charles Thomas Sell, D.D.S. Arrested.
January 29, 1998	Petition for Action on Conditions of Pretrial Release Granted; Bond Revoked; Detention of Charles Thomas Sell, D.D.S. Ordered.
April 23, 1998	Six Count Indictment of Charles Thomas Sell, D.D.S. Filed by USA, Cause No. 98CR177.
May 22, 1998	Cause No. 97CR290 and Cause No. 98CR177 Consolidated.
October 14, 1998	Notice of Intent to Introduce Evidence of Mental Disease or Defect Filed by Charles Thomas Sell, D.D.S.
October 15, 1998	Motion for Psychiatric Examination Filed by USA.
November 25, 1998	Motion for Psychiatric Examination to Determine Charles Thomas Sell, D.D.S.'s Mental Competency to Stand Trial Denied; Motion for Psychiatric Examination to Determine Charles Thomas Sell, D.D.S.'s Mental Competency on the Date of the Alleged Offenses Granted.
February 10, 1999	Motion for Hearing to Determine Charles Thomas Sell, D.D.S.'s Competency Filed by Charles Thomas Sell, D.D.S.
February 16, 1999	Motion for Psychiatric Examination to Determine Charles Thomas Sell, D.D.S.'s Competency Filed by USA.

February 22, 1999	Motion for Psychiatric Examination to determine Charles Thomas Sell, D.D.S.'s Competency Granted.
April 12, 1999	Report of Psychiatric Evaluation of Charles Thomas Sell, D.D.S. Filed.
April 14, 1999	Hospitalization and Evaluation of Charles Thomas Sell, D.D.S. for a Period of Time Not to Exceed Four Months to Determine Whether There is a Substantial Probability that, in the Foreseeable Future, Charles Thomas Sell, D.D.S. will Attain the Capacity to Proceed to Trial.
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July 2, 1999	Administrative Appeal Decision Regarding Involuntary Medication by United States Medical Center for Federal Prisons. (Not on Docket Entries).
July 30, 1999	Motion for Judicial Determination Regarding Involuntary Psychiatric Treatment and Medication Filed by Charles Thomas Sell, D.D.S.
August 20, 1999	Response to Motion for Judicial Determination Regarding Involuntary Psychiatric Treatment and Medication Filed by USA.
September 29, 1999	Evidentiary Hearing on Motion for Judicial Determination Regarding

	Involuntary Psychiatric Treatment and Medication Held.
January 24, 2000	Post-Hearing Memorandum in Support of Involuntary Medication Filed by USA.
January 24, 2000	Post-Hearing Memorandum in Opposition to Involuntary Medication Filed by Charles Thomas Sell, D.D.S.
February 24, 2000	Response to Post-Hearing Memorandum in Support of Involuntary Medication Filed by Charles Thomas Sell, D.D.S.
March 20, 2000	Report of Psychiatric Evaluation of Charles Thomas Sell, D.D.S. Filed.
August 9, 2000	Involuntary Medication of Charles Thomas Sell, D.D.S. Ordered by United States Magistrate Judge.
August 17, 2000	Motion for Reconsideration of the August 9, 2000 Order Permitting the Involuntary Medication of Charles Thomas Sell, D.D.S., to Reopen the September 29, 1999 Evidentiary Hearing Concerning the Involuntary Medication of Charles Thomas Sell, D.D.S., and to Compel the Production of Evidence of the Physical Abuse of Charles Thomas Sell, D.D.S. While Housed Pending Trial.
August 18, 2000	Motion for United State Magistrate Judge to Reconsider the August 9, 2000 Order Permitting the Involuntary Medication of Charles Thomas

	Sell, D.D.S., to Reopen the September 29, 1999 Evidentiary Hearing Concerning the Involuntary Medication of Charles Thomas Sell, D.D.S., and to Compel the Production of Evidence of the Physical Abuse of Charles Thomas Sell, D.D.S. While Housed Pending Trial Denied by United States Magistrate Judge.
August 22, 2000	Motion for United States District Court to Reconsider United States Magistrate Judge's Ruling Concerning Involuntary Medication of Charles Thomas Sell, D.D.S.
November 1, 2000	Response to Motion to Reconsider Filed by USA.
November 8, 2000	Reply to Motion to Reconsider Filed by Charles Thomas Sell, D.D.S.
December 20, 2000	Update to Reply to Motion to Reconsider Filed by Charles Thomas Sell, D.D.S.
January 5, 2001	Second Update to Reply to Motion to Reconsider Filed by Charles Thomas Sell, D.D.S.
April 4, 2001	Motion to Reconsider Order Permitting Involuntary Medication of Charles Thomas Sell, D.D.S. Denied by the United States District Court.
April 13, 2001	Notice of Appeal to the United States Court of Appeals for the Eighth Circuit Concerning Involuntary Medication Filed by Charles Thomas Sell, D.D.S.

October 15, 2001	Argued and Submitted to the United States Court of Appeals for the Eighth Circuit, Judges Pasco M. Bowman, Gerald W. Heaney, and Kermit E. Bye.
March 7, 2002	Involuntary Medication of Charles Thomas Sell, D.D.S. Affirmed by the United States Court of Appeals for the Eighth Circuit, *United States v. Sell*, 282 F.3d 560 (8th Cir. 2002) (2-1 decision) (Bye, J., dissenting).
April 8, 2002	Amended Petition for Rehearing and Petition for Rehearing *En Banc* Filed by Charles Thomas Sell, D.D.S.
April 22, 2002	Response to Amended Petition for Rehearing and Petition for Rehearing *En Banc* Filed by USA.
May 7, 2002	Petition for Rehearing and Petition for Rehearing *En Banc* Denied by United States Court of Appeals for the Eighth Circuit, *United States v. Sell,* 282 F.3d 560 (8th Cir. 2002) (5-4 decision) (Loken, J., Murphy, J., Bye, J., and Riley, J voted to grant the petition for rehearing *en banc*) (McMillian, J. took no part).
August 2, 2002	Notice of Petition for *Writ of Certiorari* Concerning Involuntary Medication Filed by Charles Thomas Sell, D.D.S.

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA, Plaintiff, v. DR. CHARLES THOMAS SELL, D.D.S. and MARY SELL, Defendants.	No. 4 97 CR00290DJS (Filed July 30, 1997)

INDICTMENT

BACKGROUND

The Grand Jury charges that at all times material to this indictment:

1. Charles Thomas Sell, the defendant herein, was a dentist practicing dentistry in St. Louis County, Missouri.

2. Mary Sell, the defendant herein, was the office manager for Dr. Charles T. Sell.

3. The defendants directed their employees to place information in claim forms which they knew was false.

4. The Missouri Medicaid Program (Medicaid) was jointly funded by both the federal government and the State of Missouri and was a state health care program as defined in Title 42, United States Code, Section

1320a-7(h). The Department of Social Services, Division of Medical Services (hereafter referred to as DMS) administered the Medicaid program in Missouri.

5. Medicaid paid the cost of certain health care expenses for qualified individuals – Medicaid recipients.

6. DMS contracted with GTE data services (hereafter referred to as GTE), to serve as its fiscal agent to handle the receipt and processing of Medicaid claims in Missouri. The claims were received and processed in Jefferson City, Missouri.

7. Upon application by a health care provider and approval by DMS, DMS assigned provider numbers to various health care providers, including dentists. The provider number allowed the health care provider to bill Medicaid directly for services rendered by the enrolled provider to patients who were eligible and received medical services under the Medicaid program.

8. Enrolled providers agreed to abide by Medicaid policies and procedures. Medicaid policy, with respect to dentists, required that the enrolled provider only bill for the services actually performed by the provider.

9. An authorized provider of dental services was reimbursed for furnishing dental services to Medicaid recipients upon submission of an application for payment to the Medicaid program.

10. Payment for dental services billed on an application are determined in part, by procedure codes. Procedure codes are numbers which are placed on the application for payment and identify a specific dental service.

COUNTS I-IV

The Grand Jury charges that:

11. On or about the dates set forth hereinafter, in the Eastern District of Missouri,

CHARLES THOMAS SELL and MARY SELL,

the defendants, herein, knowingly and willfully made, and caused to be made, false statements and representations of material facts on the applications for payment of Medicaid funds for dental service in that the defendants, Charles Thomas Sell and Mary Sell, stated and represented that Charles Thomas Sell had performed specific services, identified in part by procedure code numbers, on the dates indicated and that the defendants herein then and there well knew said statements and representations on the applications for payment were false, in that Dr. Sell had not provided the dental services as described and identified by the procedure code numbers.

Count	Patient	Date of Service	False Procedure Code on Claim
1.	Nancy R.	6-14-96	D2331
2.	Cynthia J.	12-29-95	D2331
3.	Cynthia J.	5-24-96	D2331
4.	Cynthia J.	12-13-96	D2331

All in violation of Title 42, United States Code, Section 1320a-7b(a)(1)(i).

COUNT V

Paragraphs 1-3, as set out above, are incorporated herein.

12. American Medical Security is a private health care benefit program as defined in Section 341 of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

13. American Medical Security reimbursed providers for certain services provided to persons insured by American Medical Security. American Medical Security required that the provider bill only for those services actually provided to the insured.

COUNT V

The Grand Jury further charges that:

14. On or about January 4, 1997, in the Eastern district of Missouri, in a matter involving a health care benefit program, the defendants,

CHARLES THOMAS SELL and MARY SELL

knowingly and willfully made or caused to be made a materially false document, knowing the same to contain a false and fraudulent material statement, in that the defendants knew that the claim form submitted to American Medical Security falsely and fraudulently represented that the defendant Dr. Charles Sell had placed 16 composite resin filings, identified by procedure code D2331, in the teeth of patient James M. on January 4, 1997.

All in violation of Title 18, United States Code, Section 1035(a)(2).

A TRUE BILL

/s/ Janet Horchner
FOREPERSON

EDWARD L. DOWD, JR.
United States Attorney

/s/ Dorothy McMurtry
DOROTHY L. McMURTRY
Assistant United States Attorney

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA,	)	
Plaintiff,	)	
	)	No. S1-4:97CR290
v.	)	DJS/Term
DR. CHARLES THOMAS SELL, D.D.S. and MARY SELL,	)	(Filed Nov. 6, 1997)
Defendants.	)	

INDICTMENT

BACKGROUND

The Grand Jury charges that at all times material to this indictment:

1. Dr. Charles Thomas Sell, D.D.S., the defendant herein, was a dentist practicing dentistry in St. Louis County, Missouri.

2. Mary Sell, the defendant herein, was the wife of and office manager for defendant Dr. Sell.

Medicaid

3. The Missouri Medicaid Program (Medicaid) was jointly funded by both the federal government and the State of Missouri and was a state health care program as defined in Title 42, United States Code, Section 1320a-7(h). The Department of Social Services, Division of Medical Services (hereafter referred to as DMS), administered the Medicaid program in Missouri.

4. Medicaid paid the cost of certain health care expenses for qualified individuals, referred to on occasion as Medicaid recipients.

5. DMS contracted with GTE data services (hereafter referred to as GTE), to serve as its fiscal agent and to handle the receipt and processing of Medicaid claims in Missouri. The claims were received and processed in Jefferson City, Missouri.

6. Upon application by a health care provider and approval by DMS, DMS assigned provider numbers to various health care providers, including dentists. The provider number allowed the health care provider to bill Medicaid directly for services rendered by the enrolled provider to Medicaid recipients, who had received medical services under the Medicaid program.

7. Enrolled providers agreed to abide by Medicaid policies and procedures. Medicaid policy, with respect to dentists, required that the enrolled provider only bill for the services actually performed by the provider.

8. To obtain reimbursement, authorized providers were required to submit an application for payment, or a claim form, to the Medicaid program. Payments for dental services billed on an application or claim form were determined, in part, by procedure codes. Procedure codes are numbers that are placed on the application for payment or claim form and identify a specific dental service.

Private Insurance Companies

9. Aetna, American Commercial Terminal, American Medical Security, Blue Cross/Blue Shield, Delta Dental, Provident Life & Accident, Prudential, and Western Union

(hereafter referred to collectively as Private Insurers) were private health care benefit programs or insurance companies, that reimbursed providers for specified services rendered to persons insured by their respective companies. These Private Insurers only paid for those services actually provided to the insured patient.

10. To obtain reimbursement, authorized providers were required to submit an application for payment, or a claim form, to the Private Insurers. Payments for dental services were determined, in part, by procedure codes. Procedure codes are numbers that are placed on the application for payment or claim form and identify a specific dental service.

COUNTS 1-56

(MAIL FRAUD 18 U.S.C. § 1341)

The Grand Jury realleges, and incorporates by reference, the allegations in paragraphs 1 through 10 of this indictment and further alleges:

THE SCHEME TO DEFRAUD

11. It was the purpose of the scheme that the defendants would obtain money and property by means of false or fraudulent pretenses, representations, or promises. As part of the scheme, the defendants, and their employees at their direction, submitted false or fraudulent claims to Medicaid and Private Insurers to obtain payments for dental services which they knew defendant Dr. Sell had not rendered.

12. It was further part of the scheme that the defendants, and their employees at their direction, created and

maintained patient files which reflected services which had not been rendered.

13. It was further part of the scheme that the defendants, and their employees at their direction, provided false and fraudulent information, to Medicaid and Private Insurers, when Medicaid or Private Insurers asked for justification for the claims submitted by the defendants.

14. It was further part of the scheme that the defendants altered x-rays to justify resin and amalgam fillings that defendant Dr. Sell had not provided, but for which the defendants billed Medicaid and Private Insurers.

15. It was further part of the scheme that the defendants, and their employees at their direction, submitted the x-rays of one patient to justify services provided to another patient.

16. It was further part of the scheme that the defendants, and their employees at their direction, routinely "maxed out" the insurance policies of patients within a short period of time by billing for services that defendant Dr. Sell did not render.

17. It was further part of the scheme that the defendants, and their employees at their direction, billed Medicaid and the Private Insurers for covered or reimbursable services when defendant Dr. Sell had actually provided a service that was not covered or was covered at a lower rate of reimbursement.

18. It was further part of the scheme that the defendants, and their employees at their direction, submitted, or caused to be submitted, questionnaires, that had been sent to patients by the Private Insurers to verify that defendant Dr. Sell had provided dental services to the

patients. The defendants knew that the information contained in the questionnaires was false at the time the questionnaires were submitted.

19. It was further part of the scheme that the defendants submitted, or caused to be submitted, to the Private Insurers, letters, that the defendants knew falsely and fraudulently represented that defendant Dr. Sell had provided dental services.

20. It was further part of the scheme that the defendants routinely waived co-payments from the patients of defendant Dr. Sell and concealed this fact from the Private Insurers.

MAILINGS IN FURTHERANCE OF THE SCHEME

21. It was further part of the scheme that the defendants, and their employees at their direction, used the United States mail for a variety of purposes, including submitting claims to Medicaid and the Private Insurers, receiving payments from Medicaid and the Private Insurers, and sending and receiving correspondence from Medicaid, Private Insurers, and patients.

22. Beginning in 1989 and continuing through May 1997, the exact dates being unknown to the Grand Jury, in the Eastern District of Missouri and elsewhere, the defendants,

CHARLES THOMAS SELL and MARY SELL,

and other persons known and unknown to the Grand Jury, having devised the above described scheme and artifice, for the purpose of executing and attempting to execute the above described scheme and artifice to defraud, and for the

purpose of obtaining money and property from Medicaid and the Private Insurers by means of false and fraudulent pretenses, representations, and promises, did knowingly place and cause to be placed in a post office or authorized depository for mail matter, things or matters to be sent or delivered by the postal service and then did take and receive therefrom, the following matter or things, and knowingly caused to be delivered by directions thereon claim forms and applications for payments:

Count	Patient	Date of Service	False Procedure Code on Claim
AETNA			
1.	Melvin W.	5/26/94	2331, 2332
AMERICAN COMMERCIAL TERMINAL			
2.	Jessica V.	12/31/93	2331, 2330
3.	Jessica V.	11/29/96	2330, 2331
AMERICAN MEDICAL SECURITY			
4.	Sharon E.	12/10/96	2150, 2160
5.	Sharon E.	12/17/96	2150, 2160
6.	Orville E.	12/19/96	2160, 2150
7.	Orville E.	12/23/96	2332, 2335
8.	Dmitry K.	12/23/96	2150
9.	Dmitry K.	3/27/97	2335
10.	Mato L.	10/1/96	2160, 2161, 2150
11.	Mato L.	10/15/96	2160, 2140
12.	James M.	1/4/97	2331, 2330
13.	James M.	1/15/96	2335

14.	Celine W.	11/22/96	2160
15.	Darren W.	10/29/96	2335, 9951
16.	Darren W.	11/5/96	2335
17.	Darren W.	11/12/96	2335
18.	Darren W.	11/19/96	2335
19.	Timmy W.	11/4/96	2331
20.	Timmy W.	11/11/96	2331, 2330
21.	Timmy W.	11/18/96	2331
22.	Timmy W.	11/29/96	2331, 2332, 2335

BLUE CROSS/BLUE SHIELD

23.	Celine W.	11/26/96	2160
24.	Darren W.	12/21/96	2335
25.	Timmy W.	11/29/96	2331, 2332

DELTA

26.	Scott B.	9/24/94	2330, 2331
27.	Scott B.	4/3/95	2331
28.	Scott B.	3/7/96	2331, 2330
29.	Allison B.	4/2/94	2330
30.	Laura B.	8/3/94	2330
31.	Laura B.	3/7/96	2330, 2331
32.	Laura B.	11/23/96	2335
33.	Laura B.	2/22/97	2330
34.	Betty L.	10/22/96	2335, 2332, 2331, 2330
35.	David L.	12/22/95	2330, 2331, 2335

36.	David L.	10/23/96	2330, 2331, 2335
37.	Jason L.	3/27/95	2330, 2331, 2332
38.	Nicole L.	8/1/94	2330, 2150
39.	Nicole L.	12/22/95	2335
40.	Nicole L.	6/22/93	2330
41.	Frank S.	1/18/93	2335
42.	Frank S.	12/20/93	2330, 2332, 2331
43.	Frank S.	1/5/95	2332, 2335
44.	Lynne T.	8/9/94	2330, 2331, 2332
45.	Lynne T.	12/2/95	2335

MEDICAID

46.	Cynthia J.	12/29/95	D2331
47.	Cynthia J.	5/24/96	D2331
48.	Cynthia J.	12/13/96	D2331

METROPOLITAN LIFE

49.	Mary Ann S.	1-13-94	2335, 2332
50.	Mary Ann S.	1-22-96	2335

PROVIDENT LIFE AND ACCIDENT

51.	Shaun R.	12/29/95	2330
52.	Shaun R.	11/15/96	2330

PRUDENTIAL

53.	Kim C.	2/25/97	2332, 2335
54.	David R.	5/9/95	2330

WESTERN UNION			
55.	Faye A.	12/4/93	2335, 2330, 2331, 2332
56.	Faye A.	1/31/95	2330, 2331

All in violation of Title 18, United States Code, Section 1341.

COUNTS 57-62

(MEDICAID FRAUD 42 U.S.C. § 1320a-7b(a)(1)(i))

The Grand Jury charges that:

23. On or about the dates set forth hereinafter, in the Eastern District of Missouri,

CHARLES THOMAS SELL and MARY SELL,

the defendants, herein, knowingly and willfully made, and caused to be made, false statements and representations of material facts on the applications for payment of Medicaid funds for dental service in that the defendants, Charles Thomas Sell and Mary Sell, stated and represented that Charles Thomas Sell had performed specific services, identified in part by procedure code numbers, on the dates indicated and that the defendants herein then and there well knew said statements and representations on the applications for payment were false, in that Dr. Sell had not provided the dental services as described and identified by the procedure code numbers.

Count	Patient	Date of Service	False Procedure Code on Claim
57.	Charlene A.	8/11/95	D2331
58.	Carolyn A.	2/23/96	D2331

59.	Christine C.	5/19/95	D2160, D2331
60.	Dana M.	11/29/96	D2331
61.	Dana M.	11/29/96	D2331
62.	Nancy R.	6/14/96	D2331

All in violation of Title 42, United States Code, Section 1320a-7b(a)(1)(i).

COUNT 63

(MONEY LAUNDERING 18 U.S.C. § 1957(a))

The Grand Jury realleges, and incorporates by reference, the allegations in paragraphs 1 through 20 of this indictment and further alleges:

24. On or about April 15, 1997, in the Eastern District of Missouri,

CHARLES THOMAS SELL and MARY SELL,

did knowingly engage and attempt to engage in a monetary transaction by, through, or to a financial institution, affecting interstate and foreign commerce, in a criminally derived property of a value greater than $10,000.00, that is, a deposit of funds in the amount of $21,202.00 into an account at A.G. Edwards and Sons, Inc., which account is identified as account number 98-493514-260, and "A.G. Edwards and Sons, D16, C/F C. Thomas Sell, D.D.S., FBO C. Thomas Sell Profit Sharing Plan", such property having been derived from a specified unlawful activity, that is, mail fraud.

In violation of Title 18, U.S.C. Section 1957(a).

A TRUE BILL

/s/ [Illegible]
FOREPERSON

EDWARD L. DOWD, JR.
United States Attorney

/s/ Dorothy L. McMurtry
DOROTHY L. McMURTRY
Assistant United States Attorney

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

UNITED STATES OF AMERICA,	)	
Plaintiff,	)	
v.	)	**No.**
CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL,	)	
Defendants.	)	

INDICTMENT

COUNT I

The Grand Jury charges that:

Beginning in or about December 1997, and continuing until March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, did knowingly and wilfully combine, conspire, confederate and agree with each other to kill Jane Alderman with the intent to prevent the attendance and testimony of Jane Alderman in an official proceeding, and with intent to retaliate against Jane Alderman for providing to a law enforcement officer information relating to the commission and possible commission of a Federal offense; said actions constituting violations of Title 18, United States Code, Sections 1512 and 1513; and to kill Federal Bureau of Investigation Special Agent Anthony Box, an officer or employee of the United States, on account of and while in the performance

of his official duties, said actions constituting violations of Title 18, United States Code, Section 1114.

THE CONSPIRACY

The object and purpose of the conspiracy were as follows:

1. **CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL** intended to prevent the attendance and testimony of Jane Alderman at trial proceedings against **CHARLES T. SELL and MARY SELL** in the United States District Court for the Eastern District of Missouri. The caption in that case is *United States v. Sell*, S1 4:97CR290 DJS.

2. **CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL** intended to retaliate against Jane Alderman for providing information to law enforcement officials in the investigation of **CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL** for violations of federal law.

3. **CHARLES T. SELL, a/k/a TOM SELL,** directed that Jane Alderman be killed.

4. **MARY SELL** provided an associate with Jane Alderman's home address, social security number and a description of Jane Alderman's vehicle.

5. **MARY SELL** provided an associate with currency with which he was to pay a hit man as a partial down payment for the murder of Jane Alderman and Federal Bureau of Investigation Special Agent Anthony Box.

6. **CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL** intended to retaliate against Federal

Bureau of Investigation Special Agent Anthony Box for the arrest of **CHARLES T. SELL, a/k/a TOM SELL.**

7. **CHARLES T. SELL, a/k/a TOM SELL,** referred to Special Agent Anthony Box, an African-American, in racially derogatory terms and directed that he be killed.

OVERT ACTS

In furtherance of the conspiracy, and to effect the objects thereof, the defendants committed or caused the commission of the following overt acts:

1. In or about December, 1997, **CHARLES T. SELL, a/k/a TOM SELL,** loaned Jonathan Gamble $500 with which to purchase a pistol.

2. In or about December 1997, **CHARLES T. SELL, a/k/a TOM SELL,** directed that Jonathan Gamble murder or arrange the murders of Federal Bureau of Investigation Special Agent Anthony Box, Special Agent Sal Hernandez and Special Agent Kevin Cosentino.

3. In or about January 1998, **CHARLES T. SELL, a/k/a TOM SELL,** directed that Jonathan Gamble murder or arrange the murder of Jane Alderman.

4. On or about February 6, 1998, **MARY SELL** met with Jonathan Gamble and advised him that she wanted Jane Alderman dead and that **CHARLES T. SELL, a/k/a TOM SELL,** wanted Special Agent Anthony Box dead.

5. On or about February 12, 1998, **MARY SELL** told Jonathan Gamble that it was not "cool" for an associate of theirs to talk on the telephone about locating the residence of Special Agent Anthony Box.

6. On or about February 20, 1998, **MARY SELL** frisked Jonathan Gamble to determine if he was wearing a wire.

7. On or about February 20, 1998, **MARY SELL** met Jonathan Gamble and gave him $235 as a partial down payment for another person to murder Jane Alderman and Special Agent Anthony Box.

8. On or about March 4, 1998, Jonathan Gamble met with **CHARLES T. SELL, a/k/a TOM SELL,** who advised Jonathan Gamble "you're gonna have to do this, what, what you would think I would want, . . . there's no way I can say . . . " and "Well, I'll tell you what, I'll tell you what, heres, if you're gonna do it . . . go for the big guy, man."; "For the, for the A.B., okay?"; "Aryan Brotherhood, man."

All in violation of Title 18, United States Code, Section 371.

COUNT II

The Grand Jury further charges that:

Between in or about December 1997, and continuing until March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, did knowingly and wilfully attempt to kill Jane Alderman, with intent to prevent the attendance and testimony of Jane Alderman in an official proceeding, that is, the trial of federal criminal charges pending against **CHARLES T. SELL, a/k/a TOM SELL, and MARY SELL** in the United States District Court for

the Eastern District of Missouri, under the caption *United States v. Sell*, S1 4:97CR290 DJS, and the defendants committed a substantial step in furtherance of that attempt.

In violation of Title 18, United States Code, Sections 2 and 1512(a)(1)(A).

COUNT III

The Grand Jury further charges that:

Between in or about December 1997, and continuing until March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, did knowingly and wilfully attempt to kill Jane Alderman, with intent to retaliate against Jane Alderman for providing to a law enforcement officer any information relating to the commission and possible commission of a Federal offense, and the defendants committed a substantial step in furtherance of that attempt.

In violation of Title 18, United States Code, Section 2 and 1513(a)(1)(B).

COUNT IV

The Grand Jury further charges that:

Between December 1997, and March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, did knowingly and wilfully attempt to kill Federal Bureau of Investigation Special Agent Anthony Box, an employee and officer of the United States, while Special Agent Anthony Box was engaged in and on account of the performance of his official duties, and the defendants committed a substantial step in furtherance of that attempt.

In violation of Title 18, United States Code, Sections 2 and 1114.

COUNT V

The Grand Jury further charges that:

Between in or about December, 1997 and March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, with intent that Jonathan Gamble engage in conduct constituting a felony that has as an element the use of physical force against the person of another in violation of the laws of the United States and under circumstances strongly corroborative of the intent, did solicit, command, induce and endeavor to persuade Jonathan Gamble to engage in such conduct, that is, the murder of Federal Bureau of Investigation Special Agent Anthony Box, an officer of the United States in violation of Title 18, United States Code, §1114.

In violation of Title 18, United States Code, Sections 2 and 373.

COUNT VI

The Grand Jury further charges that:

Between in or about December, 1997 and March 15, 1998, in the Eastern District of Missouri,

CHARLES T. SELL, a/k/a TOM SELL,
and MARY SELL,

the defendants herein, with intent that Jonathan Gamble engage in conduct constituting a felony that has as an element the use of physical force against the person of another in violation of the laws of the United States and under circumstances strongly corroborative of the intent, did solicit, command, induce and endeavor to persuade Jonathan Gamble to engage in such conduct, that is the murder of Jane Alderman, a witness in violation of Title 18, United States Code, Sections 1512 and 1513.

In violation of Title 18, United States Code, Sections 2 and 373.

A TRUE BILL.

_____
FOREPERSON

EDWARD L. DOWD, JR.
United States Attorney

_____
HOWARD J. MARCUS #16980
Assistant United States Attorney

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MISSOURI
EASTERN DIVISION

[Caption Omitted In Printing]

AFFIDAVIT OF C. ROBERT CLONINGER, M.D.

C. ROBERT CLONINGER, M.D., being first duly sworn upon his oath, states:

1. I am over 21 years of age; I have personal knowledge of and am competent to testify to the matters set forth in this Affidavit.

2. I am the Wallace Renard Professor of Psychiatry & Genetics at Washington University School of Medicine in St. Louis and the Director of the Center of Psychobiology of Personality at Washington University School of Medicine in St. Louis. A copy of my *curriculum vitae* is attached as *Exhibit A*.

3. This Affidavit reflects my expert opinion as a psychiatrist regarding the treatment of Dr. Charles Thomas Sell who is diagnosed as having Delusional Disorder.

4. Unlike Schizophrenia, Delusional Disorder is a rare condition, so few psychiatrists have extensive experience with this.

5. The basis for my opinion is that I have personally treated several cases of Delusional Disorder and have carried out a systematic review of the literature, including a computerized search of published literature through the National Library of Medicine from 1966 to present, and a review of psychiatric textbooks. *See*, for example, Chapter 12 of the TEXTBOOK OF PSYCHIATRY, *Schizophrenia,*

Schizophreniform Disorder, and Delusional (Paranoid) Disorders (Talbott, et al. eds.) attached as *Exhibit B*.

6. The only systematic data that I could locate about the treatment of a large series of cases of Delusional Disorder have been reported by Opjordsmoen and Retterstol (PSYCHOPATHOLOGY, Volume 26, pages 90-94, 1993), a copy of which is attached as *Exhibit C*.

7. Opjordsmoen and Retterstol reported "The effect of neuroleptics in the treatment of schizophrenia is well established. Some reports indicate that at least pimozide may be effective in delusional disorder as well. In this article a long-term follow up study of 72 first-admitted patients with delusional disorder is described. Outcome in the group admitted during 1946-1948 was compared with that of patients admitted during 1958-1961. We did *not* find a more favorable outcome in the group admitted after the introduction of neuroleptics."

8. In other words, there is no evidence that neuroleptics are beneficial for patients with Delusional Disorder.

9. Although neuroleptics are often recommended by physicians for control of agitation or psychotic symptoms, there are no data to justify this as a benefit to patients with Delusional Disorder.

10. This finding is consistent with my own experience; whereas neuroleptics are often beneficial in schizophrenia, they are not beneficial in Delusional Disorder.

11. Dr. Sell himself has been treated with antipsychotic medication in the past by Mr. McKinney at Barnes Hospital.

12. Dr. Sell's delusions did *not* respond as evidenced by his immediately discontinuing treatment with the medication and never returning to see Dr. McKinney.

13. Dr. Sell regarded that treatment as a terrible experience then and now.

14. This would not constitute an adequate trial of the medication in a patient with schizophrenia, but neither does it provide any basis to think he would be an exception to the rule that neuroleptics are not beneficial in Delusional Disorder.

15. More generally, neuroleptics may be indicated for acute control of agitation or dangerousness, but they always are associated with risk of side affects.

16. Their proposed use in Dr. Sell must be considered from the point of view of benefit versus risk and with regard to his consent.

17. In my opinion, I do not see any justification for involuntary treatments that carry any risk at all in the absence of documented evidence of benefit to the person.

18. Accordingly, in my opinion, the treatment of Dr. Sell should be limited to basic support and voluntary symptomatic treatment.

19. This would indicate a safe supportive milieu with access to exercise and reading material.

20. The voluntary symptomatic treatment should include access to continued pharmacotherapy with antidepressants, which he has found helpful to his mood and energy level in the past.

FURTHER AFFIANT SAITH NOT.

/s/ C. Robert Cloninger
C. Robert Cloninger, M.D.

STATE OF MISSOURI)
) ss.
COUNTY OF ST. LOUIS)

On this 5 day of May, 1999, before me personally appeared C. Robert Cloninger, M.D., to me known to be the person described in and who executed the foregoing instrument, and acknowledged that he executed the same as his free act and deed.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal in the City and State aforesaid, the day and year first above written.

/s/ Geraldine L. Ford
Notary Public

My commission expires:

Aug. 16, 2002

GERALDINE L. FORD
NOTARY PUBLIC STATE OF MISSOURI
ST. LOUIS CITY
MY COMMISSION EXPIRES [Illegible] 2002

EXHIBIT A

CURRICULUM VITAE

C. Robert Cloninger, M.D.
465-76-6841

Date: September, 1998

Birthplace: Beaumont, Texas

Citizenship: U.S.A.

Address: Office: Department of Psychiatry
Washington University Medical School
4940 Children's Place
St. Louis, MO 63110
314-362-7005 (phone)
314-362-5594 (fax)

Home: 7100 Delmar
University City, MO 63130
314-863-1338

Present Position: Wallace Renard Professor of Psychiatry, also Professor of Genetics & Psychology, and Director of Center for Psychobiology of Personality

Education:

University of Texas, Austin, Texas, 1962-1966, B.A. with high honors and special honors in Plan II (Philosophy, Psychology, and Anthropology).

Washington University School of Medicine, St. Louis, MO 1966-1970, M.D.

Epidemiology Field Research Trainee, California State Department of Public Health, Berkeley, California, July 1967-September 1967.

Student Research Fellow (with S.B. Guze), Washington University School of Medicine, St. Louis, Missouri, June 1969-October 1969.

Assistant Resident-Assistant and Trainee (NIMH) in Psychiatry Washington University School of Medicine, St. Louis, Missouri, July 1970-June 1973.

Research Scientist Development Awardee (NIMH) in Quantitative Genetics, July 1975-1985.

Visiting Investigator, Population Genetics Laboratory, University of Hawaii at Manoa, July 1978-June 1979.

Academic Positions/Employment:

Instructor in Psychiatry, Washington University School of Medicine, St. Louis, Missouri, July 1973-June 1974

Assistant Professor of Psychiatry, Washington University School of Medicine, St. Louis, Missouri, July 1974-June 1978.

Associate Professor of Psychiatry, Washington University School of Medicine, St. Louis, Missouri, July 1978-June 1981.

Associate Professor of Genetics, Washington University School of Medicine, St. Louis, Missouri, July 1979-June 1981

Visiting Professor of Psychiatry and Genetics, University of Umea School of Medicine, Umea, Sweden, May to June, 1980.

Professor of Psychiatry and Genetics, Washington University School of Medicine, July 1981-present.

Head, Department of Psychiatry, Washington University School of Medicine, July 1989-March 1994

Professor of Psychology, Washington University, July 1989-present.

Wallace Renard Professor of Psychiatry, Washington University, July 1991-present

Director, Center for Psychobiology of Personality, March 1994-present

Hospital Appointments:

Barnes and Allied Hospitals, St. Louis, MO
Assistant Psychiatrist, July 1973-June 1980
Associate Psychiatrist, July 1980-June 1981
Psychiatrist, July 1981-present
Psychiatrist-in-chief July 1989-March 1994

Children's Hospital of St. Louis
Psychiatrist-in-chief, July 1989-June 1991

Malcolm Bliss Mental Health Center, St. Louis, MO
Consulting Psychiatrist, July 1973-1989

Jewish Hospital of St. Louis, MO
Associate Psychiatrist, July 1976-June 1980
Psychiatrist, July 1980-Present
Director of Outpatient Psychiatry, July 1976-June 1989

Other University Appointments and Committees:

Steering Committee Member, McDonnell Center for Higher Brain Function, 1989-1993

Steering Committee Member, WUMS Howard Hughes Program, 1990-1993

Chair, Division of Biostatistics Advisory Committee, 1989-1993

Member, Health Care Administration Advisory Committee, 1989-1993

Member, Occupational Therapy Program Advisory Committee, 1990-1993

Medical Licensure and Board Certifications:

State Board of the Healing Arts of Missouri, Physicians and Surgeons #32703, issued June 20, 1970

Missouri Controlled Substance Registration #210508

Bureau of Narcotic and Dangerous Drugs #AC4359419

Diplomate, American Board of Psychiatry and Neurology, 1975

Honors and Awards:

Institute of Medicine, National Academy of Sciences, USA, elected active member, May 1989-present

Fellow, American Association for the Advancement of Science, 1996-present, for outstanding contributions in the field of psychiatry, especially alcoholism and personality disorders

Phi Beta Kappa – 1965

Phi Beta Sigma – 1963

Alpha Epsilon Delta – 1965

Sandoz Award for Research in Psychiatry, Washington University School of Medicine (1970)

Research Scientist Development Awards:
Type 1 (1975-1980) MH-0048. The transmission and prognosis of psychiatric disorders (Quantitative Genetics and Environmental Genetic Interaction)

Type 2 (1980-1985) Genetic epidemiology of psychiatric disorders

Research Scientist Award (MH-00048)
Genetic Epidemiology of Psychiatric Disorders (1985-1989) (Resigned to accept chairmanship)

Endowed Visiting Professorships
Milton and Harriet Parker Memorial Lecturer, Ohio State University, Department of Psychiatry, September 1983 and December 1985

John Nielson Distinguished Lecturer, University of Utah, Department of Psychiatry, April 1988

Stewart Wolf Distinguished Lecturer, University of Oklahoma, Department of Medicine, May 1988

James Brady Lecturer, University of Colorado, 1989

Frank H. Luton Lecturer, Vanderbilt University, 1989

William D. Stubenbord Visiting Professor,

Cornell University Medical College and the Louis Calder Foundation, September, 1991

Other Distinguished Lectureships
Sigma Xi Lecturer on Natural Sciences, University of North Carolina, October 1987

NIH Centennial Lecturer, Washington, DC, September 1987

Plenary Lecturer, Research Society on Alcoholism, June 1988

Pfizer Visiting Professor, Columbia University and New York State Psychiatric Institute, October 1991

Gudbrandsdalen Medalist & Lecturer, Norwegian Medical Research Council, Lillehammer, Norway, 1992

Keynote Speaker, Australian-New Zealand Psychiatric Association Annual Meeting, Christchurch, New Zealand, 1993 and 1996

Lederle Visiting Professor, Hospital de la Salpetriere, Paris, France, December, 1993

Plenary Lecturer, Japanese Society of Psychosomatic Medicine, Kyoto, Japan, 1996

Plenary Lecturer, American College of Psychiatry, Kauai, Hawaii, 1996

Charles E. Smith Lecturer, National Institute for Psychobiology in Israel, Hebrew University, Jerusalem, Israel (Psychobiology of Human Personality), March 5, 1998

Honorary Doctor of Medicine (M.D. honoris causa), University of Umea (Sweden), October 1983 for distinguished contributions to genetic epidemiology of psychiatric disorders

Strecker Award (The 25th Annual Institute of Pennsylvania Hospital Award in Memory of Edward A. Strecker, M.D.), 1988 for significant contributions to psychiatric patient care and treatment by studies of the assessment and inheritance of personality and psychopathology

Edgehill Newport Scientific Recognition Award, May 1990, in recognition of outstanding contributions to the treatment of chemically dependent persons through basic research

Mortimer Goodman Memorial Award, The Alliance for the Mentally Ill of Metro St. Louis, in recognition

of outstanding service as a physician, researcher, administrator, public servant and friend, May 1992

James B. Isaacson Memorial Award, June 1992, International Society for Biomedical Research on Alcoholism and National Foundation for Prevention of Chemical Dependency Disease, for excellence in scientific research into the causes of chemical dependency diseases

Samuel Hamilton Award, March 1993, American Psychopathological Association, for contributions to understanding personality and psychopathology

Adolf Meyer Award, May 1993, American Psychiatric Association, for outstanding contributions to the science and practice of psychiatry

Editorial Responsibilities:

Editor, *Behavior Genetics* (1980-1986)
Associate Editor,
American Journal of Human Genetics (1980-1983)
Journal of Clinical Psychiatry (1981-1987)
Genetic Epidemiology (1983-1991)
Human Heredity (1989-Present)
Field Editor, *Neuropsychiatric Genetics. American Journal Medical Genetics* (1992-)
Editorial Boards,
Archives of General Psychiatry (1987-)
Neuropsychopharmacology (1991-)
Comprehensive Psychiatry (1992-)
Journal of Psychiatric Research (1993-)
American Journal of Medical Genetics (1993-)
Psychiatric Genetics (1993-)
International Journal of Neuropsychopharmcology (1997-)

Professional Societies and Organizations:

Advances in Neuropyschiatry and Psychopharmacology Editorial Board – Raven Press (1991-1993)

American Association for the Advancement of Science, Member (1976-Present)

Representative of the Behavior Genetics Association Section Committee for Medical Sciences (Section N) (1986-1989)

American College of Neuropsychopharmacology, Member (1987-)

Committee on Issues of Public Concern (1988-1997)

American Medical Association, Member (1982-Present)

American Psychiatric Association, Member (1975-1979)
Fellow (1980-Present)

American Psychopathological Association, Fellow (1976-Present)
Membership Chairman (1978-1984)
Treasurer (1984-1990)
Vice-President (1990-1991)
President-Elect (1991-1992)
President (1992-1993)

American Society of Human Genetics, Member (1976-Present)

Behavior Genetics Association, Member (1976-Present)
BGA Representative to AAAS Section Committee for Medical Sciences
Chairman, Publications Committee (1986-1989)

Center for Advanced Study in the Behavioral Sciences, Academic Psychiatry Consortium (1990-1993, 1993-1996)

Eastern Missouri Psychiatric Society, Member (1973-Present)

International Society for Study of Personality Disorders,
Board of Directors – (1991-)
President, American Region – (1993-)

Psychiatric Research Society, Member (1977-Present)

Research Society on Alcoholism (1981-Present)
Committee on Research Development (1984-Present)
Member, Board of Directors (1987-1990)
Committee on Issues of Public Concern (1989-91)

Society of Biological Psychiatry, Member (1977-Present)

Consulting Relationships and Board Memberships:

Consultant, American Psychiatric Association
Task Force on Nomenclature (Diagnostic and Statistical Manual – 111), 1978-1980
Task Force to Evaluate DSM-III, 1983-
Committee to Revise DSM-III, 1984-1987
Task Force on DSM-IV, 1988-

Psychiatric Consultant and Member of Professional Advisory Council, Suicide Prevention Service of Madison – St. Clair Counties (1971-1993)

Psychiatric Consultant, 3rd Judicial Circuit of Illinois (1973-1974)

Special Consultant and Site Visitor, NIMH Clinical Program Projects and Clinical Projects Review Committees (1977-1980)

NIMH Psychopathology and Clinical Biology Research Review Committee:
Consultant and Committee Member (1980-Present)

Chairman, Psychopathology Subcommittee (June 1981-1983)
Chairman (June 1983-July 1984)

Scientific Advisory and Consultant, NIMH Affective and Anxiety Disorders Research Branch (1986-1989)

Scientific Advisory Board
Children of Alcoholics Foundation (1989-present)

Consultant to Director, NIAAA (1984-1997)
Board of Scientific Counselors (1988-1992)

Consultant, World Health Organization (WHO)/ADAMHA Advisory Group on Diagnosis and Classification of Mental Disorders, and Alcohol – and Drug-Related Problems (1981-1985)
Consultant Psychiatrist (1993-present)

Member, Research Advisory Council, Texas Department of Mental Health and Mental Retardation (1983-1985)

Extramural Scientific Advisor and Consultant
Chicago Medical School, Department of Psychiatry (1977)
New York University Medical School, Psychiatry (1980-82)
University of Minnesota, Dight Laboratories, Genetics (1985-88)
University of Connecticut, Alcoholism Research Center (1986-91)
University of Pennsylvania, Clinical Research Center (1987-present)
University of Colorado, Alcohol Research Center (1991-)
University of Oklahoma, Alcoholism Research Center (1987-92)

Honorary Member – IBC Advisory Council, 1989

Scientific Advisory Board – Oklahoma Center of Molecular Medicine, 1990

Missouri Mental Health Commission – (9/26/90-6/28/94)

Pfizer Visting Professorship in Psychiatry Academic Advisory Committee, 1993-1996

Science Advisory Board, Treatment and Research Advancements – Association for Personality Disorder – (1997-)

Science Advisory Board, Treatment and Research Advancements – Association for Personality Disorder – (1997-)

Research Support:

Governmental:

NIMH, MH31302, Epidemiological Genetics and Family Study, C.R. Cloninger, M.D., P.I.; 08/01/86-07/31/2001

NIAAA, AA07982, Prediction of Alcohol Abuse in Swedish Adoptees, C.R. Cloninger, M.D. P.I.; 07/01/88-06/30/95

NIAAA, AA08028, Molecular Genetic Studies of Alcoholic Subtypes, C.R. Cloninger, M.D., P.I.; 12/01/88-11/30/95

NIMH, MH46276, Diagnostic Center for Linkage Studies of Schizophrenia, C.R. Cloninger, M.D., P.I.; 09/30/89-08/31/94

NIAAA, AA08401, Collaborative Studies on the Genetics of Alcoholism, Coordinating Center, Theodore Reich, M.D., P.I.; 10/01/89-09/30/94

NIMH, MH46280, Diagnostic Center for Linkage Studies of Bipolar Disorder, Theodore Reich, M.D., P.I.; 09/30/89-08/31/94,

MH14677, Research Training in Clinical Sciences, C.R. Cloninger, M.D., P.I.; 07/01/92-06/30/97 (transferred to T. Reich, 7/1/93)

Teaching Titles and Responsibilities:

Coursemaster, Introduction to Clinical Psychiatry – Washington University School of Medicine II (1976-1989)

Committee on Academic Review and Promotion (1976-1989)

Lecturer, Medical Genetics, Washington University School of Medicine (1980-Present)

Clinical Sciences Postdoctoral Training Program
Preceptor (1975-Present)
Psychiatric Genetics Director (1980-Present)
Overall Program Director (1985-1993)

RESEARCH TRAINEES

Betty Lobos, B.S., Predoctoral Graduate Student (1985-1993)
Training: Quantitative and molecular genetics.
Dissertation Topic: Genetics of Nicotine Acetylcholine Receptor.

Sean Yutzy, M.D., Postdoctoral Fellow, (1990-1992)
Training: Nosology of somatoform and personality disorders
Currently: Assistant Professor of Psychiatry, Washington University School of Medicine

Dragan M. Svrakic, M.D., Ph.D., Fulbright Scholar from University of Belgrade, Yugoslavia (Sept 88-Aug 89)

Training: Collaboration on Cross-cultural studies of personality assessment and structure.
Currently, Assistant Professor of Psychiatry, Washington University School of Medicine

Stephen Dinwiddie, M.D., Postdoctoral Fellow (1987-1990)
Training: Clinical and genetic methods for studying neuroadaptive processes in substance abusers.
Currently: Assistant Professor of Psychiatry, Washington University School of Medicine

Ronald Martin, M.D., Psychiatry Resident, 1975-1977
Training: Supervised his follow-up of female felons I had previously studied; trained in conduct and analysis of longitudinal clinical studies
Currently: Professor & Chairman of Psychiatry, University of Kansas at Wichita.

Collins E. Lewis, M.D., M.P.H., Psychiatry Resident, 1975-1977
Training: Supervised clinical and family study of alcoholics; trained in epidemiological methods and family studies.
Currently: Associate Professor of Psychiatry, Washington University.

William Coryell, M.D., Psychiatry Resident, 1977
Training: Supervised his participation in a reliability study of a new structured interview; trained in methods for conducting and interpreting reliability studies.
Currently: Professor of Psychiatry, University of Iowa.

John P. Rice, Ph.D., Postdoctoral Fellow, 1975-1977
Training: Directed reading about psychiatric genetics and genetic epidemiology; we jointly

worked on extending methods for cultural inheritance and segregation analysis.
Currently: Professor of Psychiatry & Biostatistics, Washington University.

Andrew Scallet, Ph.D., Predoctoral Psychology Student, 1975-1976
Training: Supervised research on assessment and doubleblind treatment studies of outpatients.
Currently: Research Psychologist, National Center for Toxicological Research, Jefferson, Arkansas

Lenore Teter, M.D., Psychiatry Resident, 1980
Training: Supervised research on psychiatric social adjustment of recent Russian immigrants.
Currently: Instructor in Psychiatry, Washington University, then private practice

Robert Desalle, B.S., Predoctoral Genetics Fellow, 1979
Training: Method of path analysis in studying inheritance of complex phenotype systems.
Currently: Completed dissertation in Genetics, Washington University.
Currently: Department of Biology, Yale University

Peter McGuffin, M.D., Postdoctoral Fellow, 1980-1981
Training: Advanced methods of genetic epidemiology including segregation, path, admixture, and linkage analysis.
Currently: Professor & Chairman of Psychiatry, Cardiff, England

Paul Van Eerdewegh, Ph.D., Predoctoral Fellow, 1980-1982
Training: Studies of statistical properties of copaths and selection in multivariate systems relevant in quantitative genetics.

Currently: Assistant Professor in Psychiatry in Genetic Epidemiology, Washington University.

Dennis O'Rourke, Ph.D., Postdoctoral Fellow, 1980-1983
Training: Advanced methods of genetic epidemiology including segregation, path, and linkage analysis.
Currently: Professor of Anthropology, University of Utah.

Anne-Liss von Knorring, M.D., Postdoctoral Fellow, 1982-1983.
Training: Methods of genetic epidemiology relevant to adoption studies.
Currently: Professor of Child Psychiatry, University of Uppsala, Sweden.

Soren Sigvardsson, D. Med. Sci., Predoctoral Fellow, 1981 Postdoctoral Fellow, 1983
Training: Methods of genetic epidemiology and multivariate analysis relevant to adoption studies; longitudinal and cross-fostering studies of adoptees with relevance to child psychiatry.
Currently: Associate Professor of Child Psychiatry, Umea University.

Nancy J. Cox, Ph.D., Postdoctoral Fellow, 1982
Training: Advanced methods of genetic epidemiology for studying psychiatric disorders.
Currently: Assistant Professor, University of Chicago.

Eric Devor, Ph.D., Postdoctoral Fellow, 1982
Training: Advanced methods of genetic epidemiology in anthropology; population structure.
Currently: Assistant Professor of Psychiatry, University of Iowa, Iowa City

Mark Zoccolillo, M.D., Psychiatry Resident, 1983
Training: Supervised design and analysis of clinical and social comparison of matched groups of outpatients with somatoform and affective disorders; study of parenting and home environmental influences on children of outpatients.
Currently: Assistant Professor of Psychiatry, Texas Tech

Edward Lauterbach, M.D., Psychiatry Resident, 1984
Training: Design and analysis of psychiatric follow-up studies.
Currently: Associate Professor of Psychiatry, (Tenure) Mercer University School of Medicine, Macon, Georgia

Kara Forest, B.A., Biology Honors Student, 1986
Training: Etiology of anxiety states.
Currently: Medical school

Wolfgang Baier, M.D., FRG Postdoctoral Fellow, 1987
Training: Genetic epidemiology of generalized minor seizures (collaborative project with Professor Doose at University of Kiel, FRG)
Currently: Child Neurologist, University of Kiel

David Craufurd, M.D., Wellcome Trust Fellow, 1987.
Training: Psychiatric Genetics.
Currently: Research Psychiatrist, St. Mary's Hospital, University of Manchester, England.

Sheila B. Gilligan, B.S., Predoctoral Graduate Student (1983-1988)
Training: Quantitative genetics of common diseases. Dissertation Topic: Genetic and Phenotypic Heterogeneity in Alcoholism (scheduled to complete Spring, 1988).
Currently: Postdoctoral Fellow in Human Genetics, Medical College of Virginia (Dr. Andrew Heath), then Peace Corps in Africa.

Vicky Ryan, Undergraduate biology honors student (1987-1988)
Training: Techniques in family studies of alcoholism.
Currently: Medical School, University of Missouri

David L. Garver, M.D., Sabbatical Leave from University of Cincinnati, Depts. of Psychiatry and Pharmacology (Sept 88-Aug 89)
Training: Psychiatric genetics including clinical and molecular aspects.
Currently: Professor of Psychiatry, Southwestern Medical School, Dallas, Texas

Harald and Gabrielle Aschauer, M.D., Medical Research Council of Austria Fellows
Training: Neuropsychopharmacologist/psychiatrist coming for training in genetics of schizophrenia (Sept 87-March 1989).
Currently: Assistant Professors in Vienna

Bibliography

Articles – 1970

1. Cloninger CR and Guze SB: Psychiatric Illness and Female Criminality: The Role of Sociopathy and Hysteria in the Antisocial Women. *Amer. J. Psychiat.*, 127(3):303-311, 1970.

2. Cloninger CR and Guze SB: Female Criminals: Their Personal, Familial, and Social Backgrounds (The Relations of These to the Diagnoses of Sociopathy and Hysteria). *Arch. Gen. Psychiat.*, 23:554-558, 1970.

Articles – 1973

3. Cloninger CR and Guze SB: Psychiatric Illness in the Families of Female Criminals: A Study of 288

First-Degree Relatives. *Brit. J. Psychiat.*, 122:697-703, 1973.

4. Cloninger CR and Guze SB: Psychiatric Disorders and Criminal Recidivism: A Follow-up Study of Female Criminals. *Arch. Gen. Psychiat.*, 29:266-269, 1973.

Articles – 1974

5. Hearst ED, Cloninger CR, Crews EL, and Cadoret RJ: Electrosleep Therapy: A Double Blind Trial. *Arch. Gen. Psychiat.*, 30:463-466, 1974.

6. Cloninger CR: Group Rape: A Commentary. Med. Aspects of Human Sexuality, 8:81, 1974.

7. Cloninger CR, Packman PM, Cicero TJ, Boshans RL, and Robins E: Morphine Dependence and Enzyme Activity in the Hypothamus. *Biochem. Pharmacol.* 23:983-988, 1974.

Articles – 1975

8. Cloninger CR and Guze SB: Hysteria and Parental Psychiatric Illness. Presented at the Annual Meeting of APA, 1973. Psychol. Med., 5:27-31, 1975.

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EXHIBIT B

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Chapter 12

Schizophrenia, Schizophreniform Disorder, and Delusional (Paranoid) Disorders

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* * *

□ DELUSIONAL (PARANOID) DISORDERS

Delusional (paranoid) disorders constitute a small but important group of disorders. The *DSM-III-R* includes persecutory, jealous, erotomanic, grandiose, and somatic subtypes, all unified by the presence of a dominant, well-systematized, and encapuslated nonbizarre delusion accompanied by affect appropriate to the delusion; personality deterioration is minimal.

History

The term *paranoia* has ancient roots. From the Greek *para nous*, meaning "a mind beside itself," the term was originally used in Greek literature to describe insanity or "craziness." The term fell into disuse but was revived in the early 19th century by German psychiatrists who were interested in disorders characterized by delusions of persecution and grandeur (Lewis 1970; Tanna 1974). Kahlbaum, in 1863, used the term to describe a chronic delusional condition. Kraepelin separated paranoia from dementia praecox and, like Kahlbaum, was concerned with longitudinal course. Kraepelin gradually altered his concept of paranoia, so that by the eighth revision of his *Lehrbach der Psychiatric*, he had restricted the term to describe those with systematized delusions, an absence of hallucinations, and a prolonged course without recovery but not generally leading to mental deterioration. He also identified *paraphrenia* as an intermediate group of paranoid disorders between dementia praecox and paranoia

characterized by unremitting systematized delusions and hallucinations without progression to dementia. The latter term is still used commonly in Britain. Bleuler agreed that paranoia was separate from dementia praecox but differed from Kraepelin in maintaining that hallucinations could occur in some cases. He was particularly interested in the psychological development of the disorder.

Modern Scandinavian practice is to regard delusional disorders as reactive, arising in persons with vulnerable constitutions subjected to stress. Their term, paranoid psychotic reaction, would include contemporary American concepts of paranoia, but also schizophreniform and schizoaffective disorders.

Contemporary American thought on the disorder is represented in *DSM-III* and is remarkably similar to the definition put forth by Kraepelin in 1912 and 1919. The ICD-9 defines paranoia similarly. Winokur (1977) suggested that paranoid disorder be renamed *delusional disorder* to rid the diagnosis of the ambiguity inherent in the term *paranoia*, which most persons construe to mean persecutory. Winokur and others have demonstrated that delusions found in paranoid disorders are not restricted to delusions of persecution or jealousy. These suggestions have now been incorporated into the revision of *DSM-III* (1987). Kendler (1980) has further proposed that in the absence of hallucinations, the term *simple delusional disorder* be used and that when hallucinations are present the term *hallucinatory delusional disorder* be used.

Epidemiology

Little is known about the true incidence and prevalence of delusional disorder. Much of our knowledge is based on

retrospective data of hospitalized patients and may not be generalizable. Kendler (1982) recently reviewed 17 reports on the frequency of paranoia for hospital admissions. He determined that delusional disorder constituted between one and four percent of psychiatric admissions and between two and seven percent of admissions for functional psychosis. He calculated the incidence of first admissions for paranoia to be between 1 and 3 per 100,000 per year and the prevalence to be between 24 and 30 per 100,000 population. From these reports, Kendler concludes that paranoia is an illness predominantly manifesting itself in middle to late adult life with a peak frequency of first admissions between 35 and 55 years of age. Patients are more likely to be female than male, with most reports showing that between 36 percent and 48 percent of first admissions are men. Sixty to 75 percent of patients first admitted are married, but up to one-third are widowed, divorced, or separated at the time of admission. Patients with the disorder are judged to be relatively socially disadvantaged, both in economic and educational terms, and are often immigrants. Kendler notes that these demographic characteristics are unlike those for schizophrenia or affective disorder and consistent with the hypothesis that delusional disorder is a distinct entity.

These data differ from those presented by Winokur (1977) in a chart review of 29 paranoics admitted to a state psychiatric hospital over a 50-year period. The 29 patients constituted 0.14 percent of all hospital admissions. Like Kraepelin, Winokur found that males predominated 70:30. He also found that 94 percent had an age of onset between ages 20 to 49, that over half had been ill more than four years at the time of admission, and that most patients had a satisfactory work history. In his study, more than half had IQs less than 90.

Etiology

Little is known about the genesis of delusional disorders. As one would expect, most theories involve genetics, the environment, or psychodynamics.

The weight of evidence suggests that delusional disorder is unrelated to either schizophrenia or affective disorders. In a recent review, Kendler (1980) found no increase in risk for affective illness in families of paranoid probands; two of three family studies reporting on the risk for schizophrenia showed a two-fold increased risk, while the other showed no increase. In a reanalysis of the Copenhagen sample of the Danish adoption study of schizophrenia, Kendler et al. (1982) found that cases of schizophrenia spectrum disorders (schizotypal personality and schizophrenia) were strongly concentrated in the biologic relatives of schizophrenic adoptees but not in adoptees with delusional disorder. A recent family study of 32 paranoics by Watt (1985) also found an increased risk for schizophrenia in first degree relatives of schizophrenics but not for paranoid or depressed probands.

Apparently, patients with delusional disorder differ from schizophrenics premorbidly as well. In three relevant studies (Kendler 1980), they are noted to be more extroverted, dominant, and hypersensitive, while schizophrenic patients premorbidly tend to be schizoid, introverted, or submissive. Unfortunately, there are no comparisons with affective disorders.

It is possible that psychosocial stressors have a role in the etiology of delusional disorder. Certain rare paranoid conditions illustrate this possibility. *Induced psychotic disorder* (shared paranoid disorder), or "folie a deux," occurs when delusions are transferred from one individual to another. Usually the dominant person in the relationship

develops a delusion; it is later passively adopted by the other. *Migration psychoses* are described in persons migrating to foreign countries. Certainly, persons in whom paranoia is prone to develop may be more likely to immigrate than others, but it is also possible that the particular psychosocial stress associated with immigration plays a causal role in the development of the psychosis. *Prison psychosis* has been described in which isolation in prison, especially solitary confinement, may lead to paranoia. *Querulent paranoia* is a special form of paranoia characterized by litigiousness and is believed by Scandinavian investigators to be a psychogenic disorder in which unlucky personal experiences precipitate paranoia in persons with deviant personalities. How, or why, these situations should lead to the development of paranoia is unclear.

The psychodynamic origin of paranoia stems from Freud's analysis of the Schreber case (Freud 1958a). Freud believed persecutory delusions to stem from unconscious homosexual urges defended against by denial and projection. However, there is apparently no increase in delusional disorder among homosexuals and vice versa.

Clinical Features and Differental Diagnosis

Delusional disorders, according to *DSM-III-R* (see Table 7), consistent of nonbizarre delusions lasting at least one month and involving situations that occur in real life, behavior that is not obviously odd or bizarre apart from the delusion or its ramifications, absence of schizophrenic symptoms such as bizarre delusions or grossly disorganized speech or behavior, no prominent hallucinations, and absence of an affective disorder or organic mental disorder. The core feature, however, is the presence of a

well-systematized nonbizarre delusion – a fixed false belief in the presence of an otherwise clear sensorium. Winokur (1977) found delusions of persecution, reference, and jealousy to be the most common while hypochondriacal delusions and delusions of grandeur are less common. Sexual problems and depressive symptoms are frequent and patients may show overtalkativeness or circumstantiality, especially when discussing their delusions. In his study, the patients were not considered fussy or obsessional by their families, but were considered to have been chronically jealous or suspicious. Interestingly, Winokur (1985) found these traits to be typical of family members as well.

TABLE 7. *DSM-III-R* CRITERIA FOR DELUSIONAL (PARANOID) DISORDER

A. Nonbizarre delusion(s) (that is, involving situations that occur in real life, such as being followed, poisoned, infected, or loved at a distance; having a disease; being deceived by one's spouse or lover) of at least one month's duration.

B. Auditory or visual hallucinations, if present, are not prominent.

C. Apart from the delusion(s) or its ramifications, behavior is not obviously odd or bizarre.

D. Major depressive or manic syndrome, if present, was brief in duration relative to the duration of the psychotic symptoms.

E. Has never met criterion A of schizophrenia (see Table I) and it cannot be established that an organic factor initiated and maintained the disturbance.

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Associated features may include anger, social isolation and seclusiveness, eccentric behavior, suspiciousness, hostility, and rarely violence. Many patients become litigious and end up as lawyers' clients rather than as psychiatrists' patients.

According to *DSM-III-R* delusional disorder includes the following subtypes: persecutory, jealous, erotomanic, grandiose, and somatic. *Unspecified type* is a residual category for patients who cannot be subtyped in the previous groups. Patients ill less than one month would be classified as either having a brief reactive psychosis or an atypical psychosis. In *DSM-III* this would have been classified as an acute paranoid disorder. The *DSM-III* category shared paranoid disorder, or "folie a deux," occurs when two or more persons share a delusion. This is a rare disorder and its incidence and prevalence are unknown. In *DSM-III-R* it is termed *induced psychotic disorder* and is grouped with psychotic disorders not elsewhere classified, rather than with delusional disorder.

Several variants of delusional disorder have been described and include (in addition to those identified earlier): *conjugal paranoia*, which is limited to the delusion about a spouse's perceived infidelity; *erotomani* (De Clerambault's syndrome), wherein a person, usually female, develops the belief that another person, usually an older male of social importance, is in love with her; hypochondriacal paranoia, wherein a patient has the unshakable belief of having a physical illness; Capgras syndrome, wherein a patient believes a person closely related to him or her has been replaced by a double; and Fregoli syndrome, in which the patient identifies a familiar person in various other people he or she encounters. The patient

may maintain that although there is no physical resemblance between the familiar person and others, they are nonetheless psychologically identical. It is important for a clinician to consider schizophrenia or an organic mental disorder as the cause of these variants. The following case report illustrates conjugal paranoia:

Case Example

H.M. is a 64-year-old electrician who lives with his wife of 43 years. Although his father was alcoholic, and his family poor, H.M. was well adjusted as a child, achieved good grades in school, and participated in sports activities, although he was considered somewhat aloof and distant by his peers. After graduating from high school he had married and joined the Army, serving honorably in World War II. After the war he worked as an electrician, eventually opening his own business. Although hard-working, he was viewed as overly rigid and humorless by his family and had few friends. H.M. and his wife had three children, all of whom were healthy and emotionally stable.

Several years after returning from the war, he began to suspect his wife of infidelity and over the ensuing decades continued to be convinced that his wife was constantly involved with other men. Although he had never seen her with another man, he was nevertheless convinced by trivial evidence such as frequently washed bed linen, spots on his wife's undergarments, or tire tracks in the driveway that did not belong there. He had accused his wife of placing sleeping pills in his coffee at night so that she would be able to leave the house for a liaison with her lover after he had fallen asleep. He maintained that on

several occasions his wife actually had sexual relations with another man in the same bed where he lay sleeping. On one particular occasion, he noted awakening to find the bed sheets in disarray and his shorts pulled down to his knees in what he believed was his wife's lover's attempt to harass him. He had also claimed that neighbors had commented to him about the large number of men who visited his wife when he was away.

His wife first became aware of his suspiciousness and jealousy early in their marriage and steadfastly maintained that there was no basis for the accusations. No amount of reassurance could alter her husband's convictions, however. She reported that during their marriage her husband's beliefs would wax and wane, alternating with periods of relative normalcy. Although she continued to love and care for him, his wife admitted that the delusional beliefs had strained the marriage and had led to several separations.

H.M. voluntarily presented for hospitalization reporting that he was tired of his wife calling him "crazy" and wishing to settle the matter. During the hospital stay he was friendly and appropriate, but persisted with the unshakable belief that his wife had been unfaithful to him. There was no evidence of hallucinations. A trial of antipsychotic medication did not alter his belief.

Diagnosis

Because delusional symptoms are common and frequently accompany both functional and organic illnesses, a careful diagnostic assessment is necessary. First, a thorough physical and history must rule out organic causes for delusional disorder. Delusional symptoms have been found

in a variety of organic illnesses including alcoholism; amphetamine-, cocaine-, and other-drug-induced states; dementia; and infectious, metabolic, and endocrine disorders (Manschreck and Petri 1978).

Routine lab tests may be helpful in ruling out organic causes. If mass lesions are suspected, CT or MRI may be useful in selected cases but are not routinely necessary.

The major differential remains in separating delusional disorder from affective disorder, schizophrenia, and paranoid personality. The chief distinction is that in delusional disorders, a full depressive or manic syndrome is absent, developed after the psychotic symptoms, or was brief induration relative to the duration of the psychotic symptoms,. Unlike schizophrenia, delusional disorder is characterized by nonbizarre delusions and generally either absence of hallucinations or hallucinations that are not prominent. Furthermore, patients with delusional disorder do not develop other schizophrenic symptoms, such as incoherence or grossly disorganized behavior, and personality is generally preserved in areas not involving the delusion. Persons with paranoid personality are suspicious and hypervigilant, but do not have delusions.

Treatment (Pharmacology and Psychotherapy)

There are no systematic data on treatment approaches and results in delusional disorder. Nonetheless, a combination of psychosocial and physical measures seems prudent. The initial obstacle is getting the patient to the physician. Because of distrust and suspiciousness this may be particularly difficult, and might account for the low percentage of cases reported by physicians. Hospitalization is indicated if a potential for danger is present;

otherwise outpatient management is advisable. In some cases, involuntary hospitalization will be mandatory, if the threat of self-harm or harm to others is present. Unfortunately, involuntary hospitalization may increase distrust and resentment and perhaps fuel a patient's persecutory delusions.

Tact and skill are necessary to persuade a patient to accept treatment. It may help to first convince the patient that he or she should have treatment for associated depressive symptoms or anxiety and not his or her delusions. Once a therapeutic relationship has been established, the physician may then gently challenge the patient's beliefs by showing how they interfere with the patient's life. The physician must neither condemn nor collude in the beliefs. Also, the patient should be assured of confidentiality and the physician should not discuss matters with the patient's family without the patient's awareness.

Insight-oriented psychotherapy and group therapy are generally not recommended because suspiciousness and hypersensitivity may lead to misinterpretation. Some clinicians, however, believe that dynamic approaches can be helpful (Meissner 1986). Needless to say, any psychosocial treatment recommendations are based on clinical observation, not empirical evidence.

Antipsychotic medication may be useful, particularly for accompanying anxiety, agitation, and psychosis. Although many investigators are pessimistic, others suggest that specific forms of delusional disorder, for example, monohypochondriacal paranoia, may have a good response to antipsychotic medication (Munro 1978). Any of the standard antipsychotics may be used, the type and

dose of which depending on age and side effects. Because patients may be suspicious of medication, depot forms may be helpful, once it is determined that the patient benefits from the medication.

Other treatments have been tried, including electroconvulsive therapy, insulin shock therapy, and psychosurgery, but results have not been encouraging, and these approaches are not recommended.

Course and Prognosis

Kahlbaum and Kraepelin both recognized the importance of longitudinal follow-up and both believed patients with delusional disorder to have a chronic, unremitting course. Winokur (1977) found that 79 percent of hospitalized patients were discharged to the community (in contrast, only 26 percent of schizophrenics were), but on follow-up averaging 2.6 years, 69 percent were chronically ill, though 31 percent were considered "socially recovered." Retterstol (1970) found on long-term follow-up that 79 percent of his cohort [sic] were self-supporting and 74 percent had had no major periods without work; comparable figures for schizophrenics were 31 percent and 30 percent, respectively. Only 39 percent of delusional disorder patients had been hospitalized since initial discharge and 27 percent were psychotic in follow-up, compared with 90 percent and 80 percent of schizophrenics, respectively. Follow-up studies are consistent in suggesting that 80 to 90 percent of patients with delusional disorder are diagnostically stable over time. It is unlikely, for example, for these patients to develop schizophrenia. Prognostic features have not been systematically studied.

□ AFTERWARD

Substantial progress has been made during the past decade in our understanding of schizophrenia, schizophreniform disorder, and delusional disorder. While the introduction of the *DSM-III* criteria in 1980 narrowed the definition for schizophrenia, thereby creating a more homogeneous group for research, questions remain about whether the narrowing has gone too far. A reemphasis on the importance or the negative symptoms of schizophrenia, or Bleuler's "fundamental" symptoms, has emerged, balancing the perhaps too rigid emphasis on Schneiderian symptoms in the 1970s. Advances in classification and epidemiology have allowed us to reevaluate the distribution of schizophrenia and its risk factors. Despite the drawbacks of the Epidemiologic Catchment Area project, this study has become the model for future community surveys.

The development of new brain imaging techniques such as computerized tomography, magnetic resonance imaging, regional cerebral blood flow, positron emission tomography, and brain electrical activity mapping have enhanced our understanding of schizophrenia. This technology is allowing us to explore the nature and pattern of brain deficits and examine the possibility of symptom localization in schizophrenia. The development of "brain banks" as well as new techniques in histopathology have given renewed emphasis to postmortem research, permitting a more detailed investigation of abnormalities in neurotransmitter systems and in the neuropathology of schizophrenia. While the nosologists and neuroscientists have been clarifying the classification and pathologic mechanisms of schizophrenia, geneticists have been

amassing large family data sets and applying new methods such as gene mapping that promise to enrich the study of genetic factors in schizophrenia.

While technological advances are helping us to explore the etiology of schizophrenia, knowledge about course and outcome has been enhanced through long-term studies. We have also learned that the best treatment approach to schizophrenia combines both pharmacologic and psychosocial measures. Although the pharmacologic treatment of schizophrenia has been hampered by the well-worn dopamine theory, investigators are now looking at other neurotransmitter systems that may yield a more complex interactive model of neurotransmission and thus new pharmacologic approaches. meanwhile, research has highlighted the importance of family interaction models in schizophrenia, leading to more specific psychosocial interventions in the treatment of schizophrenia.

Progress during the coming decade will build upon the foundation of current research. The future appears bright and, one hopes, will lead to a better understanding of the pathophysiology and etiology of schizophrenia. This should eventually allow physicians to offer more to those who suffer from schizophrenia, perhaps psychiatry's greatest scourge.

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EXHIBIT C

Original Paper

Psychopathology 1993;26:90-94

Outcome in Delusional Disorder in Different Periods of Time

Possible Implications for Treatment with Neuroleptics

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Abstract

The effect of neuroleptics in the treatment of schizophrenia is well established. Some reports indicate that at least pimozide may be effective in delusional disorder as well. In this article a long-term follow-up study of 72 first-admitted patients with delusional disorder is described. Outcome in patients admitted during 1946-1948 was compared with that of patients admitted during 1958-1961. We did not find a more favourable outcome in the group admitted after the introduction of neuroleptics. This contradicts our earlier finding for patients with schizophrenic psychoses, indicating that neuroleptics generally may be more effective for schizophrenics than for patients with delusional disorder. Controlled drug trials in delusional disorder are strongly needed.

Several studies have demonstrated the effect of neuroleptics in the treatment of schizophrenics [1]. Recently especially pimozide has also been reported to be beneficial in the treatment of patients with monosymptomatic psychoses, meeting the criteria of delusional disorder according to current classification [2-5]. These patients are, however, often difficult to treat because of denial, projection and reluctance to take drugs. We have earlier reported that some hospitalized patients with delusional order may recover without any specific treatment other than short hospitalization, and some may recover after antidepressive treatment as well [6-8]. In our large sample of patients with delusions as a prominent feature, most patients were admitted after the introduction of neuroleptics, but a relatively large subsample was admitted before the neuroleptic era [9]. For the 141 patients with the diagnosis of schizophrenia or schizophreniform disorder according to DSM-III, it was found that average outcome was more favourable for those patients who were admitted after the introduction of neuroleptics. Moreover, the late clinical course tended to be stable in men, while women on average deteriorated. This is consistent with the hypothesis that estrogen may have postsynaptic antidopaminergic effects like neuroleptics, and protect female patients until age 40-45 [9]. We have also investigated the outcome according to gender in a sample of patients with delusional disorder, where the trend was the opposite as for the schizophrenic patients, namely that female patients did best at the follow-ups, and with the largest difference at last follow-up in the multivariate analysis [10]. The purpose of this study was to examine the difference of outcome between the group of patients with delusional disorder admitted before and after the introduction of neuroleptics.

Material and Methods

The selection of patients and follow-up procedures have been described elsewhere [11-13]. The patients were first-time delusional cases consecutively admitted to the Psychiatric Department, University of Oslo, during 1946-1948 (long-term group) and 1958-1961 (short-term group). Bipolars and patients with confusional states were excluded. One of the authors (N.R.) selected the sample and carried out a personal follow-up in 1963-1964 [11], and another follow-up of the short-term patients in 1966-1967 [12]. About 20 years later the other author (S.O.) personally examined the patients still alive and willing to be interviewed [7, 13]. Diagnosis at discharge from index admission based on the records had been assessed before the last follow-up interviews. Of 301 patients, 71 met Kendler and Tsuang's [14] diagnostic criteria for delusional disorder. These criteria are very similar to those for delusional disorder in DSM-III-R [15], but require an illness onset before age 60. Therefore, an additional patient who developed delusions at age 60 was included, so there were 72 patients, 49 men and 23 women. The mean age at admission was 40 years (range 16-61). The interviews at last follow-up were conducted semistructurally using SADS-L [16] in 42 patients; 24 had died, and 6 patients refused, had moved abroad or were untraceable. Additional information from the Norwegian Central Register for Psychoses, hospital records, family doctors, relatives and death certificates was taken into consideration. The overall psychosocial functioning was estimated using Global Assessment Scale (GAS) [17]. Gas scores were also assessed retrospectively at earlier follow-up (first follow-up in the long-term group and short-term group when insufficient information at second follow-up, otherwise second follow-up). This means that we have GAS scores at 2 points in most patients, at 3-18 (mean 10) year follow-up in the total

sample, and at 22-39 (mean 27) year follow-up in the patients examined at last follow-up. Psychosocial stressor associated with outbreak of psychosis was estimated according to axis IV in DSM-III [18]. The interrater reliability for discharge diagnosis at index hospitalization was estimated based on the same information from the records for 2 raters. The kappa value [19] for Kendler's delusional disorder was 0.86. The reliability of axis IV score was estimated in the same manner, with an intraclass correlation coefficient (ICC) [20] of 0.72. ICC for the GAS ratings was 0.89 at earlier follow-up and 0.87 at last follow-up [13]. Statistical analyses used Student's t test and the x^2 test with Yates correction. Significance was set at 5%.

Results

Table 1 shows that there were no significant differences between the two groups as regards the main delusion at index admission. In more than half of the patients delusions of persecution were predominant, while delusions of jealousy were predominant in nearly one fourth of the sample. Other main delusions were less frequent. Table 2 demonstrates that there were no significant differences between the two groups as to sex distribution, marital status, duration of symptoms at index admission or stressor score associated with outbreak of psychosis. Almost all the short-term patients received neuroleptics during the observation period, while only one fourth of the patients from the long-term group did so, and in these cases later in the course of the illness. During the total observation period long-term patients had taken neuroleptics for a mean of 3.5 years versus mean 8.2 years for the short-term patients. Short-term patients also more likely received antidepressants (43 vs. 6% of cases), but there

was no significant difference as to outcome no matter whether patients had received antidepressants or not (not shown in the table). No statistically significant differences as regard outcome were found between the groups.

Table 1. Main delusion at index admission according to cohort

	Long-term group (admitted 1946-1948)		Short-term group (admitted 1958-1961)	
	n	%	n	%
Persecution	10	56	29	54
Jealousy	4	22	12	22
Reference	2	11	4	7
Hypochondriacal	2	11	3	6
Grandeur	–	0	2	4
Sexual	–	0	2	4
Others	–	0	2	4
Total	18	100	54	101

Table 2. Background variables and GAS score at 10- and 27-year follow-up, mean values or percent of sample

	Long-term (n=18)	Short-term (n=54)	p
Male	72	67	NS
Ever married	71	84	NS
Duration of symptoms, years	1.5	1.6	NS
Axis IV score	3.4	3.3	NS
Neuroleptics ever	25	96	<0.00
GAS score (SD), 10-year	65 (20)	61 (14)	NS
GAS score (SD), 27-year	58 (22)[1]	64 (18)[2]	NS

[1] n=8.
[2] n=34.

Discussion

Contrary to what we found for schizophrenic patients [9], the subsample of patient with delusional disorder admitted in the late fifties and early sixties, after the introduction of neuroleptics, did not show a more favourable outcome than the subsample admitted in the forties. The trend was rather that long-term patients did best at 10-year follow-up. Certainly, the tendency was that short-term patients functioned best at last follow-up, but the long-term group then was very small because of attrition of patients. The results from the last follow-up must therefore be interpreted with caution. Gabriel and Schanda [21] compared the results from their follow-up studies of patients developing a delusional psychoses in midlife, who fell ill before and after the introduction of neuroleptics respectively. They did not find any difference between the two studies as to the frequency of uniform versus polymorphous or episodic versus chronic course. A comparison with our study is difficult because of different methodology and at least partly different diagnostic categories. However, the results of Gabriel and Schanda [21] point in the same direction as ours. A conclusion of our studies is that the late clinical outcome in short-term schizophrenic patients admitted after the introduction of neuroleptics was more favourable than in long-term patients admitted before neuroleptics were available. No such difference was found in patients with delusional disorder. As regards gender differences there was a trend for male schizophrenic patients to do better in the long run than their female counterparts, while in delusional disorder the trend was opposite. A possible explanation could be that neuroleptics generally may be of more important value for schizophrenic patients than for patients with

delusional disorder. Another explanation might be that there are more problems with compliance in delusional disorder than in schizophrenia. Paranoid patients are usually very sensitive to all side effects of drugs, and most reports on the effect of neuroleptics in delusional disorder are still anecdotal. Drug treatment in this disorder, therefore, still seems to be terra incognitia, and controlled drug trials are strongly needed. It also remains to be demonstrated if the effect of pimozide is specific. Because of the difficulties encountered in doing research in this field, trials should be carried out on a multi-centre basis.

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INVOLUNTARY MEDICATION REPORT

USMCFP, Springfield, Missouri	Forensic Study
Institution	Institution Security Level
SELL, Charles Thomas	26864-044
Name of Inmate	Register Number
April 19, 1999	Delusional Disorder, Perscutory Type, Paranoid Personality Disorder, Provisional
Date of Mental Health Commitment	Diagnosis

I. Notice of Hearing:

A. Advance written notice of the hearing was given to the inmate on May 27, 1999 at 9:00 AM
(Date) (Time)
by Dwayne Walker, LCSW.
(Staff Member)

B. The hearing was convened on June 9, 1999 at 12:00.
(Date) (Time)

C. The inmate was advised of his rights at the hearing by Dwayne Walker on May 27, 1999 and
(Staff Member) (Date)
a copy of the notice and advisement form is attached.

II. Staff Representative:

A. Inmate requested staff representative
Michelle Goldberg, Nurse who appeared.
(Name)
Yes __ No XX She was not available.

B. Staff representative Dwayne Walker, LCSW was
(Name)
appointed and appeared.
Yes XX No __

III. Presentation of Evidence:

A. Inmate denies that psychotropic medication is required.

B. Summary of Inmate Statement: "I do not want to take medicine. I do not want my chemistry altered. My brain is working well."

Please see addendum A – copy of Dr. Sell's written statement which he read during The Hearing concerning his beliefs that he, being a dentist in the Army Reserve, was ordered to Brooke Army Medical Center before Waco because the government planned to burn the Branch Davidian Complex and might need him to identify those who died. He also believes that he was sent to Alaska, to be away from the continental United States and not be available to testify. He believes the FBI wants to keep him silent and therefore is persecuting him. These beliefs are interfering with his ability to work with his attorney rationally and to proceed with trial since he is convinced the system is against him. Please note that he writes in the second person, as if he's writing about someone else, frequently a symptom of schizophrenia.

C. Witness:

1. Inmate requested witness: Yes XX No __

2. The following persons were called and appeared.

Thomas Bugel ____ Gordon Lee Baum ____

3. A summary of the testimony of each witness is attached. Yes

4. The following persons requested were not called for the following reason(s).

Walter McGuire – Repetitive
Stephen Sell – No telephone number. See attached.
Brother John DePaul – Had testimony from 1997 trial.
David Baugh – Repetitive
Gerald Martnek – Repetitive
Margery Martnek – Repetitive.
Joan Bystrom – See attached.
Father John Stonisck – Repetitive
Paula Chamberlain – See attached.
Mary Sell – Wife – "No Contact"
Colonel John Roberts – Repetitive
Dr. Abraham Phillips – Repetitive
Rebecca Shrum – Repetitive
Frank Reedy – Repetitive
Dr. Brion – Not found.
Jean Stehle – See attached.

5. Unavailable witness were requested to submit written statements and those statements were considered. Yes XX No __ N/A __

Please see Addendum B – contact with requested witnesses: The Hearing, usually held as early as possible in the stay of an inmate was postponed on several occasions to allow us to contact his requested witnesses and to accommodate the schedule of attorneys who were present. Since this Hearing is an administrative process inside the

Medical Center, we usually have few witnesses requested, and attorneys are not present.

D. Documentary Evidence:

In addition to the notice and advisement form, the following information was considered:

1. Court order committing the inmate for mental health care and treatment.
   Yes XX No __
2. Psychiatric/psychological reports submitted at the commitment hearing.
   Yes XX No __
3. Treatment proposal and justification.
   Yes XX No __
4. Alternative to medication.
   Yes XX No __ N/A __

IV. Findings:

A. The inmate suffers from a mental disorder.
   Yes XX No __

B. The hearing psychiatrist believes that the inmate does require psychotropic medication. Medication is required because the inmate:

1. Is gravely disabled/dangerous to self or others in the institution?
   Yes __ No XX

   He is considered dangerous based on threats and delusions if outside, but not necessarily in prison.

2. Is unable to function in open population?
   Yes __ No XX

3. In order to become competent for trial?
   Yes XX No __
4. Is mentally ill and dangerous, and medication is necessary to treat the mental illness?
   Yes XX No __

V. Specific information relied upon to support findings:

1. Court order for treatment dated April 14, 1999, by Terry I. Alderman, U. S. Magistrate Judge.
2. Psychological Forensic Report dated June 20, 1997, written by Robert Denney, PsyD. This report was prepared with little cooperation from Dr. Sell. Dr. Denney found him competent to return to court.
3. Psychological Forensic Report dated April 7, 1999, by Paul Zohn, M.A. and Richart DeMier, Ph.D. This report found Dr. Sell to be suffering from a Delusional Disorder, Persecutory Type and Paranoid Personality Disorder, provisional. He was found not competent to proceed leading to the current Court Order for treatment. (See section V, 1 above.)
4. Medical records since admission on April 20, 1999. Dr. Sell has functioned in an open unit since admission. He was placed in Competency Restoration Group. On April 22 and April 29, 1999, he participated in the group only showing some cynicism regarding how the "System really works" and "displeasure in his legal representation." On May 6, he participated in the group as he did again on May 27, 1999.

   On June 3, 1999, he became more disruptive to the group, speaking about how "corrupt" the legal system is. Efforts to return to more useful communication failed. "It was decided that he will no

longer attend group until such time as he can behave appropriately."

He remained on Paxil, an antidepressant medication at his request. He is described as being disheveled at times.

5. Past records revealed Dr. Sell had been in Barnes Hospital, St. Louis, in September 1982, with a diagnosis of Schizophrenia treated with Haldol. At that time he was preoccupied with the gold he used for fillings being contaminated by communists.

   In 1997, Dr. Sell stated he discovered the AIDS virus. In October 1997, he was preoccupied with being "followed by the Army, and/or government, FBI and the Pentagon." Currently he is charged with Conspiracy To Commit Murder and Fraud.

6. Hearing: The Hearing was held June 9, 1999, and it was audio taped. Present at the Hearing were Richart DeMier, Ph.D.; Paul Zohn, M.A.; James Wolfson, MD; Dwayne Walker, MSW; Mr. Lawless from Public Defenders Office; Mr. Marcus the Assistant United States Attorney; Dr. Sell; and Dr. Glazzard, Hearing Officer. Dennis Bitz, Medical Center attorney was also present part of the time as were two visiting witnesses, Gordon Lee Baum and Thomas Bugel. Dr. Sell had requested eighteen witnesses, but some could not be located, some gave a written or verbal response and some would have been repetitive. Both Mr. Baum and Mr. Bugel have known Dr. Sell a long time and each from his relationship (Mr. Baum as a friend and civil attorney and Mr. Bugel as friend and former member of St. Louis District School Board) separately stated he knew

of no evidence for Dr. Sell having a mental illness or requiring psychiatric medication.

A packet from Dr. Cloninger, Wallace Renard Professor of Psychiatry at Washington University Medical School in St. Louis, who examined Dr. Sell, contained his diagnosis of Dr. Sell as suffering from a Delusional Disorder and his belief that medication rarely helps a person suffering from a delusional disorder. Dr.'s DeMier and Wolfson and Mr. Zohn presented clinical evidence leading to their diagnosis and reasons for medical treatment.

Their main concern is the persistence of Dr. Sell's belief that the Courts, FBI, and federal government in general are against him, and this preoccupation will interfere with Dr. Sell's capacity to work with his attorney to make rational decisions for himself in court. They believe that Dr. Sell's symptoms point to a diagnosis of Delusional Disorder but also recognize that there well may be an underlying Schizophrenic Process.

Mr. Zohn noted that Dr. Sell believes he invokes spirits of the dead, hears whips cracking and believed that power lines were responsible for his being suicidal. Dr. DeMier noted that Dr. Sell's probable hallucinations and age of onset of his illness suggests a diagnosis of schizophrenia. Delusions can be symptoms of schizophrenia.

Dr. Wolfson stated that Dr. Sell suffers from psychotic symptoms, regardless of the precise illness and that antipsychotic medication is indicated. He said there are no adequate alternatives except electro-convulsive therapy which is not planned and possibly Reserpine, an anti-hypertensive medication with antipsychotic effects but poorly

tolerated side effects. Dr. Wolfson also noted that the early course of Dr. Sell's illness suggested schizophrenia. The record also had suggested use of nitrous oxide a dental anaesthetic which could have caused abnormal behavior. Either schizophrenia with visual hallucinations or a substance such as nitrous oxide could have caused his panic call to police because of Dr. Sell's seeing a leopard in his office, then seeing the leopard getting on a bus and telling police to "shoot me." Dr. Wolfson stated that it is not uncommon to deny hallucinations after arriving at a hospital in order to appear more well. Dr. Wolfson stated that the popular notion that persons with a delusional disorder (not necessarily caused by schizophrenia) do not respond to antipsychotic medications is inaccurate. The "key feature in choosing a therapeutic modality is the symptoms present." (Not necessarily the cause of the symptom.) Dr. Wolfson also noted that Dr. Sell's reasoning is distorted in other ways which interferes with his reality testing as indicated by the following:

> He believes he is still on active duty and that the Geneva Convention should dictate his treatment here, including allowing him to work in the dental clinic. "In reality, persons on active duty would be managed by a parallel military justice system" if his offense had occurred while on active duty.

During the Hearing Dr. Sell defended some of his thoughts, considered by some to be delusional, and persisted in his concerns that the government is against him. He associates his presence in San Antonio at the time of the Waco incident and his later orders to Alaska as related to his being needed in Waco to identify bodies and then

Alaska to remove him from the continental United States so he wouldn't be available to testify against the government. He sees the government as his enemy. Aside from his preoccupation with the government as his enemy, he has been apparently quite successful in the U. S. Army Reserve.

Dr. Sell has been in open population here. The USMCFP is a prison separating its clientele from the public and from other inmates who might be dangerous to each other. Being in open population here does not suggest he would not be dangerous if out of prison. He is charged with Conspiracy to Commit Murder. He is considered a potential danger to others in this context at this time.

Other witnesses who were contacted included Paula Chamberlain who said she had no idea about medicine and suggested calling his wife, and JoAnn Bystrom who stated she has not seen him recently, but said she had not seen signs of mental illness for the past fifteen years. Jean Stehle, Recreational Therapist at the USMCFP, wrote that he occasionally verbalizes grandiose ideations regarding his wealth and abilities but otherwise participated in recreational activities.

Attempts to contact his wife, Mary Sell, brother, Steve Sell, and former psychiatrist, Dr. Brion, were unsuccessful.

Dr. Cloninger saw Dr. Sell for evaluation. His comments regarding diagnosis and treatment are considered. Also, Mr. Lawless, from the Public Defender's Office questioned staff about dangerousness and about the various changes in dates for the Hearing.

Ten witnesses were not contacted at the decision of the Hearing Officer. The ten witnesses are:

Mr. McGuire – a friend and dental patient.
Brother John DePaul – a friend and fellow parishoner.
David Baugh – free lance correspondent.
Gerald Martnek – friend and dental patient.
Mergery Martnek – retired U. S. Army and dental patient.
Father John Stanick – pastor.
John Roberts – director Missouri Medical.
Abraham Phillips – family pediatrician and dental patient.
Rebecca Schrum – friend for forty years.
Frank Reedy – accountant.

These witnesses were not contacted because it is believed their testimony would be repetitive.

7. The large file related to Dr. Sell's career in the U. S. Army Reserve.

VI. Medication Approved: Yes XX No __

VII. Justification for Medication:

Dr. Sell suffers from fixed ideas, not held by others, that do not seem to interfere with his ability to understand the nature and consequences of the proceedings against him but do interfere with his ability to assist his attorney properly in his defense. These fixed ideas, not held by others, are called delusions. Therefore, he has been found incompetent to proceed.

Although Dr. Cloninger has had less success with antipsychotic medications treating a delusional disorder, Dr. Wolfson stated that he has found antipsychotic medication to be a treatment of choice in his experience.

Antipsychotic medication is indicated as the treatment of choice at this time. Because Dr. Sell's delusional thinking also has made him considered dangerous, antipsychotic medication if effective should help relieve him of this problem. Other forms of medication would not treat the primary symptom but could be helpful for other symptoms if the need arose. (For example, antidepressant medications or anti-anxiety medications.) They do not specifically treat delusional symptoms. Other forms of treatment such as seclusion (locked away from others) or restraints (physically held down to prevent danger to others or himself) could be helpful if necessary, but do not specifically treat delusional symptoms. Again, antipsychotic medication is indicated at this time.

VIII. Appeal Rights:

The inmate has been advised of the findings, specific evidence relied upon, medication approval and justification. The inmate has also been advised that he may appeal the medication decision within 24 hours to the Administrator of the Mental Health Division and that the administrator has 24 hours after receipt of the appeal to render a decision. A copy of this report has been given to the inmate. Yes __ No __

IX. /s/ C. D. Glazzard, M.D.
C. D. Glazzard, M.D.
Reviewing Psychiatrist

Delivered to inmate on _____ (Date) at _____ (Time) by

_____ (Staff Member) _____ (Signature) _____ (Printed Name)

INVOLUNTARY MEDICATION
HEARING APPEAL RESPONSE

DATE OF HEARING: 06/09/99

You were afforded all mandated due process rights. Specifically, you were advised of the hearing at least 24 hours prior to the hearing in order to provide you adequate time for preparation. You were afforded the opportunity to select a staff representative who, subsequent to selection, requested to have her name withdrawn due to a work schedule change that caused her to be unavailable at the time of the hearing. As a result, a suitable staff representative with sufficient education and experience was appointed by the Associate Warden (Mental Health). You were afforded the opportunity to select witnesses. You initially requested seventeen witnesses. Six witnesses were deemed to have relevant information regarding the hearing issues and eleven were determined to have merely repetitive evidence. Of those six witnesses who were selected, two could not be reached, two provided phone testimony, and two appeared at the hearing. Before the hearing, you requested an additional staff witness who was approved by the hearing officer. The additional witness you requested provided written testimony. You were afforded the opportunity to be present at the hearing to provide written or verbal evidence in your behalf. You made a verbal statement to the hearing officer and provided additional documentary evidence in the form of a handwritten statement, excerpts from a past trial transcript, and various military documents. Following the hearing, you were provided a written copy of the hearing officer's report.

A review of your medical record and the involuntary medication hearing proceedings clearly indicates that your

attending clinician and the hearing officer independently concluded that you are mentally ill and would benefit from psychotropic medication based on their assessment of data in the medical record, your response to hospitalization, and their interviews with you. The hearing officer's findings that you would benefit from psychotropic medication are based on substantive evidence, namely, the following specific and historic data:

1. An order from a U.S. District Court dated 04/14/99, committing you for treatment to restore competency to stand trial.

2. A pretrial forensic report which formed the basis for the above noted judicial order. That report outlined the opinion of a mental health professional that you were not competent to stand trial due to the presence of a thought disorder characterized by delusions of a persecutory nature involving various governmental officials and agencies, former employees, regulatory agencies, and members of the legal profession. That report also noted that you expressed self-reported atypical experiences commonly associated with mental illness, including hearing things that others are unable to hear and being able to invoke spirits to communicate with the dead.

3. You have a prior history of hospitalization at Barnes Hospital where you were treated with anti-psychotic medication after experiencing apparent delusional beliefs that gold used for fillings had been contaminated by the communists.

4. In the past, you were admitted to Lutheran Hospital after calling the police and reporting that a leopard was in your office.

5. The direct testimony during the hearing from Psychology Intern, Mr. Zohn, and Psychologist DeMier

established that you express delusional beliefs. The referenced delusions include your perceived involvement in the Branch Davidian stand-off and your recurring, but unsubstantiated, belief that the FBI is attempting to discredit you.

6. The testimony from Psychologist DeMier and Psychiatrist Wolfson established that, regardless of the specific diagnostic label, you suffer from a psychotic disorder characterized by delusions of a persecutory nature. The most effective treatment for psychotic symptoms is anti-psychotic medication. In his testimony, Dr. Wolfson clearly stated that, while there may be a clinical difference of opinion regarding the efficacy of medication in treating delusional disorders, the key to clinical decision-making is not the diagnosis, but rather the symptoms. In Dr. Wolfson's opinion, the symptoms of mental illness you exhibit are most likely to respond to treatment if you receive anti-psychotic medication.

Based on the material presented, the hearing officer concluded that:

A. You are suffering from a psychotic disorder which impairs your ability to stand trial.

B. Anti-psychotic medication represents the most likely medical intervention which may ameliorate the symptoms which you exhibit, to the extent that you could be rendered competent to proceed with the charges against you.

C. Other less restrictive interventions such as verbal therapies, activity based therapies, minor tranquilizers, seclusion or physical restraints, in and of themselves, are unlikely to alleviate the delusional symptoms of your psychotic disorder.

D. While you may not represent a significant risk of danger to trained correctional staff inside a prison setting, your current charges of conspiracy to commit murder, coupled with your pervasive belief that you are being targeted for nefarious actions by various governmental, regulatory, and private parties, render you a potential risk to the safety of one or more others in the community.

With reference to the due process procedural issues related to your representation, limitation of witnesses, lack of objectivity by the hearing officer, appropriateness of grounds for decision-making relative to the utilization of psychotropic medication and the role of dangerousness in the decision-making process, the due process hearing was conducted and the decisions were rendered in accord with the provisions in the Code of Federal Regulations, Sections 549.40 through 549.43.

With reference to your due process procedural concerns, the regulation specifies that witnesses "should be called if they have information relevant to the inmate's mental condition and/or need for medication, and if they are reasonably available. Witnesses who only have repetitive information need not be called." The hearing officer properly adhered to these regulations. The hearing officer declined to call witnesses who would present repetitive testimony. Available witnesses were contacted and appeared. Testimony from unavailable witnesses who were above to be contacted was provided through your staff representative. Witnesses who could not be contacted did not testify.

In accordance with the Code of Federal Regulations, the hearing was "conducted by a psychiatrist who is not currently involved in the diagnosis or treatment of the

inmate." The psychiatrist who presided over your hearing fully met that criteria. The presumption of his objectivity and fairness is not automatically undermined by the psychiatrist's supervisory relationship with the psychiatrist who presented evidence at the hearing. You offered no convincing evidence which established that the reviewing psychiatrist was impartial or unfair.

Under the provisions of 28 CFR, Section 549.43, the hearing officer "shall determine whether treatment or psychotropic medication is necessary in order to make the inmate competent for trial or is necessary because the inmate is dangerous to self or others, is gravely disabled, or unable to function in open population of a mental health referral center or a regular institution." This language succinctly addresses both your concerns about the basis for due process decision-making and the role of dangerousness. The language clearly indicates that restoration of competency is a criteria independent from the other specified criteria set forth in the regulation. The decision of the hearing officer was also based on specific evidence, (your delusional beliefs with respect to various agencies, departments, and individuals). In short, the hearing officer's findings were not arbitrary or capricious, but were based upon specific evidence presented by witnesses who evaluated your condition and who have the added responsibility for planning a course of treatment for you.

Even if your dangerousness to others was a decisional component for the administration of antipsychotic medication that was causally linked with the substantive criteria of restoration to competency, the evidence presented at the hearing regarding your potential danger and risk to the safety of others meets such a requirement. Specifically, your pending charges of conspiracy to commit murder

coupled with evidence that you experience delusions of persecution at the hands of various unnamed individuals and agencies, renders you a potential risk to others in the community.

Based on the above, the hearing officer's decision that you would benefit from the utilization of anti-psychotic medication is hereby upheld.

7/2/99	8 35 AM	/s/ [Illegible]
(Date)	(Time)	(Signature)